

West View Health Village, Broadway, Fleetwood FY7 8GU

Dr Robert A C Smyth

Dr Michael M Aziz

Dr Anthony Buckley

Dr Thomas Marland

Tel: 01253 957500

**NEW PATIENT QUESTIONNAIRE**

|  |  |
| --- | --- |
| **PATIENT DETAILS** | |
| Surname: | Given Name: |
| Calling Name: | Date of Birth: |
| Gender: Male □ Female □ | Marital Status: |
| Address:  ………………………………………………………………………………………………………………………………………………………………………………………  …………………………………………………………………………. Post code: ……………………………………………………………………………………… | |
| Home Tel No: | Mobile Number: |
| Work Tel No: | Are you happy to receive  text messages from the surgery?  Yes □ No □ |
| Email address: | NHS No: |
| Next of kin: | Relationship: |
| Height (approx.): | Weight (approx.): |
| Next of kin’s contact number: | |
| Consent to discuss your medical details/conditions with them: Yes □ No □  Name of person with parental responsibility for child registering:  School child attends or will be attending: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **ETHNICITY** | | | |
| Please circle which one applies to you | | | |
| White British | Irish | | Chinese |
| Black Caribbean | African | |  |
| Asian Indian | Pakistani | |  |
| Other (please state): | | | |
| Mixed White + black Caribbean | | White + Black African | |
| White + Asian | | Other: (please state) | |
| Main spoken language: (please state)  ……………………………………………………………………. | | Interpreter required? (please tick)  Yes □ No □ | |

|  |
| --- |
| **CARER INFORMATION** |
| Do you currently have a Carer?  Yes □ No □  Are you a Carer for somebody else?  Yes □ No □  If you have answered Yes to either of these questions please fill in the Carers identification and consent form that comes in this pack. |

|  |
| --- |
| **SOCIAL WORKER DETAILS** |
| Do you currently have a Social Worker?  Yes □ No □  Could you please provide the contact details of your social worker: |

|  |
| --- |
| **MEDICATION** |
| **If you are taking regular medication, prescribed by your previous GP please attach a copy of your ‘right side’ prescription sheet. Failure to do so may delay any requests for repeat medication.**  **We can now send your medication electronically to your chosen Chemist, if you consent to this, please tick the below box and nominate a local chemist of your choice. Please find enclosed some more information on EPS or ask at our reception desk.**   * **I consent to the Electronic Prescription Service**   **Please send my medication to:** |

|  |
| --- |
| **ALLERGIES** |
| Are you allergic to any medication, substance or food(s)?Yes□ No □  If Yes, please give details:  …………………………………………………………………………………………………………………………………………………………………………………….. |

|  |  |  |
| --- | --- | --- |
| **SMOKING STATUS** | | |
| Do you smoke? | Yes □ No □ | |
| If yes,  How many cigarettes do you smoke a day? ………………..  If you are a cigar smoker please tick: Yes □ No □  If you smoke roll ups how many ounces of tobacco do you smoke a day: ………………..  How old were you when you started smoking? ……………….. | | |
| Would you like advice on giving up?  Yes □ No □ | | (For staff use only) Stop smoking card given  Yes □ No □ |
| **EX SMOKERS** | | |
| How old were you when you stopped smoking? : ……………………………………….  How many cigarettes did you smoke a day?: ………………………………………………. | | |

|  |
| --- |
| **EXERCISE** |
| Doyou take regular exercise?Yes □ No □  If yes, what sort of exercise? ………………………………………………………………………………………………….  How many times a week? ……………………………………………………………………………………………………… |

|  |  |
| --- | --- |
| **PERSONAL MEDICAL HISTORY** | |
| Please tick Yes or No if you suffer from any of the following: | |
| Heart Disease: Yes □ No □ | Diabetes: Yes □ No □ |
| COPD: Yes □ No □ | Asthma: Yes □ No □ |
| Hypertension: Yes □ No □ | Rheumatoid Arthritis: Yes □ No □ |
| Epilepsy: Yes □ No □ | Any other conditions, please list: |
| Please list any serious illnesses/operations/accidents/disabilities (and for any pregnancy related problems) and the year they took place: | |

|  |
| --- |
| **FAMILY HISTORY** |
| Have any of your family members suffered from any of the following before the age of 65?  Heart Disease (Heart attacks, Angina): Yes □ No □  If Yes, please state which family member(s) : |
| Stroke/TIA: Yes □ No □  If Yes, please state which family member(s) …………………………………………………………………………. |
| Cancer: Yes □ No □  If Yes, please state which family member(s) …………………………………………………………………………  Site of Cancer? ……………………………………………………………………………………………………………………… |

|  |
| --- |
| **ALCOHOL** |
| TO BE COMPLETED BY ALL PATIENTS  For the following questions please tick the answer which best applies  1 drink = ½ pint of beer or one glass of wine or 1 single spirit |
| How often do you have EIGHT or more drinks on one occasion?  Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily □ |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking?  Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily □ |
| How often during the last year have you failed to do what was normally expected of you because of drinking?  Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily □ |
| In the last year has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?  No □ Yes, on one occasion □ Yes on more than one occasion □ |

|  |  |
| --- | --- |
| **FOR WOMEN USE ONLY** | |
| Have you ever had a Cervical Smear?  Yes □ No □ | If Yes, please give details of when and where:  ……………………………………………………………………. |
| Are you prescribed any method of contraception?  Yes □ No □ | If Yes, please state what type and name:  ……………………………………………………………………. |
| Are you currently pregnant  Yes □ No □ | What is your expected date of delivery?  Date: …………………………………………………………… |
| If Yes, did you receive a pregnancy pack from the reception staff? Yes □ No □ | |

|  |
| --- |
| **Military** |
| **Are you in the Military service?** Yes □ No □ |
| **Are you a Military Veteran?** Yes □ No □ |

|  |  |
| --- | --- |
| **PREVIOUS GP** | |
| If you are registering for the first time you will need to provide a valid passport and a utility bill from your place of residence:  (Staff use only)  Passport provided: Yes or No …………..  Utility Bill provided: Yes or No …………. | Please give details of your previous GP (If applicable)  Dr Name: ………………………………………………..  Practice Name: ……………………………………….  Address: …………………………………………………  ……………………………………………………………….  Post Code: ……………………………………………..  Telephone: ……………………………………………. |
| Date of completion of this form: | |

**Every patient that registers at the practice will be assigned a ‘Named GP’, this will be one of our 4 partners. Your Named GP is assigned for administration purposes only and you can see any GP at the practice when you require an appointment.**

**Thank you for completing this questionnaire. The information you have provided will be assessed and you may be invited for an initial appointment for a medication review with our practice pharmacist.**

**Failure to attend this appointment may result in a delay in obtaining any repeat medication you are taking.**